PCP/Clinic Name

CARDIOVASCULAR RISK REDUCTION COMMUNICATION RECORD

Patient: Please complete section A for your health care provider when you go for your office visit. Ask your provider to complete Section B. If you use a Personal Heart Care Wallet Card or other means to keep track of the dates and results of your exams and a list of your current medications, take this information with you and show it to your health care provider.

Section A. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Telephone Number: (____) _____

Name of Specialist or Primary Care Provider (PCP): _____

PCP Address: _____

PCP Telephone Number: (____) _____ PCP Fax Number: (____) _____

Section B. Specialist/Primary Care Provider(PCP) – Results of Laboratory Tests & Recommendations

Test date:	Laboratory Test	Results	Treatment	Recommendations/Follow-up
	Total Cholesterol			
	LDL Level			
	HDL Level			
	Triglycerides			
	Glucose			
	C-Reactive Protein			
	A1C			

Other Treatment Recommendations:	
PCP/Specialist Name (Print):	
SIGNATURE – PCP/Specialist:	
Address:	
Telephone Number:	Fax Number:

Fax or mail this completed form to the patient's specialist(s) or Primary Care Provider.

(Extra copies can be downloaded at: http://dhfs.wisconsin.gov/Health/cardiovascular/index.htm)